AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445240	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/21/2013

45th 7/05/13

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to have proper signs at exits. The finding included: Observation on 5/21/13 at 9:10 AM revealed the delayed egress doors in the following locations did not have the correct signs: Exit door by room 134, exit door by the smoking area, and exit into courtyard. This finding was acknowledged by the maintenance director and the executive director during the exit conference on 5/21/13.	K 038	K038 1. Corrective Action Proper signage has been placed by the delayed egress doors by room 134, exit door by smoking area and exit to courtyard by the maintenance staff on 6/11/13. 2. Identification The maintenance director checked all other doors to ensure proper signage. 3. Measurement The maintenance staff will audit all exit doors for one month to ensure compliance. 4. Monitoring The Administrator will submit the results of the observations to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for one month. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	7/1/13
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under	K 066		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE 6/5/13

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institutio ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for r /iding it is determined that lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ›gram participation. ve are disclosable 90 days

JUN 11 2013

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445240	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 1 direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure metal containers with self-closing cover devices into which ashtrays can be emptied were readily available to all areas where smoking is permitted. The finding included: Observation on 5/21/13 at 9:16 AM revealed there were no metal containers with self-closing cover devices into which ashtrays can be emptied in the designated smoking areas. This finding was acknowledged by the maintenance director and the executive director during the exit conference on 5/21/13.	K 066	K066 1. Corrective Action Self closing smoking devices were placed in the resident smoking area by the maintenance staff on 5/24/13. 2. Identification All other areas were found to be in compliance by the maintenance staff. 3. Measurement The maintenance director or designee will audit the smoking areas for self closing devices weekly for one months then monthly for two months to ensure compliance has been maintained. Results will be given to the administrator for review. 4. Monitoring The Administrator will submit the results of the observations to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for one month. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

7/1/13

JUN 11 2013

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445240	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the fire walls. The finding included: Observation on 5/21/13 at 9:26 AM revealed the fire wall in the attic by room 108 did not have drywall tape and mud on the seems of the drywall panels; the fire wall in the attic by room 228 had a penetration around data cable through the wall. This finding was acknowledged by the maintenance director and the executive director during the exit conference on 5/21/13.	K 130	K130 1. Corrective Action The fire wall in the attic by room 108 has been properly repaired by the maintenance staff at the time of inspection. 2. Identification All other fire walls were found to be in compliance during the survey inspection. 3. Measurement The maintenance director or designee will audit firewalls at least monthly for two months and will submit results to the administrator. 4. Monitoring The Administrator will submit the results of the observations to the Quality Assurance Committee, consisting of the Medical Director, Executive Director, Director of Nursing, and at least 3 other staff members for two months. The Quality Assurance Committee will review these results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and or/ the audits reviewed for 3 months or until 100% compliance is achieved. The Executive Director will monitor to ensure continued compliance.	7/1/13

JUN 11 2013